

# **Montana State Auditor's Office**

**JOHN MORRISON**

**REPORT OF THE**

**MARKET CONDUCT EXAMINATION**

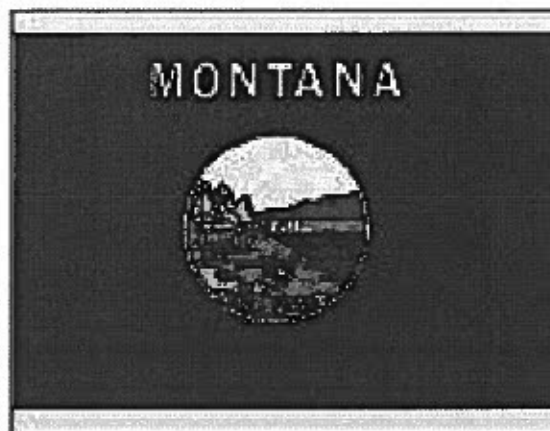
**OF**

**BLUE CROSS AND BLUE SHIELD OF MONTANA**

**(NAIC # 53686)**

**HELENA, MONTANA**

**AS OF JUNE 30, 2006**



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May 12, 2008

The Honorable John Morrison  
Montana State Auditor  
840 Helena Ave.  
Helena, Montana 59601

Dear Auditor Morrison:

Pursuant to your authority delegated under the provisions of §§ 33-1-401, 33-30-105 and 33-31-401, MCA, and in accordance with your instructions, a market conduct examination of the business practices and affairs has been conducted on:

Blue Cross and Blue Shield of Montana  
P.O. Box 4309  
560 N. Park Ave.  
Helena, Montana 59604

The Company is a Montana domiciled health service corporation, hereinafter referred to as "BCBSMT" or the "Company." The examination was performed as of June 30, 2006, at the home office in Helena, Montana.

The report of examination is herewith respectfully submitted.

## **SCOPE OF EXAMINATION**

This market conduct examination of the Company covered a six and one-half year period from January 1, 2000 through June 30, 2006.

This examination was conducted pursuant to the provisions of §§ 33-1-401, 33-30-105 and 33-31-401, MCA, and in accordance with procedures and guidelines outlined in the Market Conduct Examiners Handbook as adopted by the National Association of Insurance Commissioners (NAIC) and/or agreed upon procedures approved by the Montana State Auditor's Office (SAO).

In order to determine the practices and procedures of the Company's operations, the following procedures were performed in each phase:

1. Samples of files were selected from various populations and each file was then tested, with the results of testing for various attributes recorded in the examination workpapers.
2. The Company responded to a series of memoranda requesting information, and written inquiries regarding the testing of its contracts/certificates/policies, files, and Company practices and procedures.

This examination was comprised of the following twelve phases:

1. Company Operations and Management
2. Complaint Handling
3. Appeals/Grievances Procedures
4. Marketing and Sales
5. Network Adequacy
6. Producer Licensing
7. Provider Credentialing
8. Policyholder Service
9. Quality Assessment and Improvement
10. Underwriting: Applications, Issued Files, Declined Files, Cancelled Files, Rescinded Files and Certificates of Creditable Coverage
11. Utilization Review
12. Claims and Pre-Authorization of Services

The Market Conduct Examination consisted of a review of information, materials, documents and files requested by the examiners and supplied by the Company. Upon review of the documents, any concerns, discrepancies or questions were noted and the Company was notified in writing with an "inquiry form." The inquiry form provided space for the Company to respond in writing, either in agreement with the findings or to explain or justify the Company's action regarding the issue(s) raised by the examiners. After consideration of the Company's responses, any invalid or non-issue comments are eliminated from the final report findings.

The Report of Examination will contain an explanation of the procedures performed and the findings and conclusions reached in each phase of the examination. Examination report recommendations that do not reference specific insurance laws, rules and bulletins may be presented to encourage improvement of company practices and operations and to ensure consumer protection. Examination findings may result in administrative action by the Montana State Auditor's Office (SAO).

All unacceptable or non-complying practices may not have been discovered during the course of the examination. Additionally, findings may not be material to all areas that would assist the Insurance Commissioner of Montana. Failure to identify specific Company practices does not constitute acceptance of such practices. Additionally, a report of examination should not be construed to endorse or discredit any insurance company or insurance product.

## **COMPANY OPERATIONS AND MANAGEMENT**

### **HISTORY & PROFILE**

In 1929, a prepaid hospital plan was created at Baylor University in Texas. It was known as the Hospital Service Association (HSA). The Hospital Service Association entered Montana in 1940 and in 1964 became known as Blue Cross of Montana.

Montana Physicians Service (MPS), a Blue Shield Company, was created in 1946, when 200 physicians agreed to accept MPS reimbursement as a payment-in-full for their services.

Blue Cross of Montana and MPS merged in 1986 to become Blue Cross and Blue Shield of Montana (BCBSMT), and was formed as an independent not-for-profit health services corporation. BCBSMT is a locally operated licensee of the Blue Cross and Blue Shield Association, a system of 42 plans throughout the United States.

BCBSMT has administered both Medicare Part A and B in Montana since the inception of the Medicare program. In addition, BCBSMT has served as the lead carrier for the Montana Comprehensive Health Association (Montana's High Risk Pool and HIPPA Portability Pool) since its inception.

During 1990, BCBSMT was licensed to provide managed care services, and later offered point-of-service plans under this license. Therefore, BCBSMT is licensed to offer both fully insured and managed care products in the State of Montana.

The Company serves more than 230,000 customers in Montana and 140,000 Medicare beneficiaries.

The Company offers the following lines of health insurance products in the State of Montana:

1. Traditional Indemnity insurance
2. Point-of-Service and Managed Care benefit plans
3. High Deductible Health Plans and HSAs
4. Medicare Part "D" and Medicare Advantage plans
5. Other Supplemental Medicare plans
6. Coverage for federal employees, retirees, and dependents through the Federal Employee Program
7. Administrative Service Options for Montana Employers who are self-insured
8. Arrangements for active duty military, their dependents and retirees through CHAMPUS/TriWest
9. Short term coverage
10. Administers the Montana BlueCHIP program, which is sponsored by the Department of Health and Human Services. It is designed to provide low-income families that are not eligible for Medicaid with health insurance.
11. Administers the Montana Comprehensive Health Association for the State of Montana. This is a high-risk pool for individuals who have no group coverage and are not eligible for non-group coverage for medical reasons. It also supplies access for federal eligible individuals to health insurance without pre-existing conditions.
12. Administered both Medicare A and B for Montana residents since the inception of the Medicare program.
13. Administered both the Montana State Employee Plan and Montana State University Plans during the time periods of this exam.

In the 2004 and 2005 Annual Statement (Schedule T), the Company's total Accident and Health insurance premiums were \$326,815,310 and \$340,437,690 respectively. The Company's premiums for the Federal Employees Benefits Program were \$59,825,734 and \$62,279,646 during 2004 and 2005, respectively.

BCBSMT officers as of December 31, 2005 were as listed below:

Sherry Cladouhos	President & CEO
Terry Cosgrove	Executive Vice President & General Counsel
Wayne Knutson	Treasurer, Vice President Finance & CFO
Tanya Ask	Vice President Government Affairs
Mark Burzynski	Vice President Health Affairs
Marianne Krpan	Vice President Member Services & Support
Michael Frank	Vice President Corporate Integrity
James Vanvig	Assistant Vice President Actuarial & Reporting
Michael Wagner	Vice President Government Programs & Corporate Treasury
Jane Delong	Vice President Strategic Planning
Kirk Smith	Vice President & Chief Actuary
Randal Cline	Senior Vice President External Operations
Sheldon Boe	Assistant Vice President Information Services
Mary Belcher	Acting Corporate Secretary

There were 28 members in key positions (upper Management Personnel) who terminated their employment between January 1, 2000, and June 30, 2006, including the following:

Year Employment Ended	Name of Officer/Director	Title
2000	Joseph Donohoue	TL Finance
2001	Mike Becker Terry Screnar	VP & General Counsel CEO & Board Chairman
2002	Chuck Butler Lawrence Shannon	VP Government/Public Relations Corp. VP
2003	James Chricton, MD Janice VanRiper Thomas Cladouhos	Medical Director VP & General Counsel VP Information Systems CIO
2004	Keith Wolcott Roy Arnold, MD	CEO Montana Care and Montana Health Corporate Medical Director
2005	Peter Babin Richard Kibler	President, CEO, and Board Chairman Director Internal Audit
2006	Wayne Knutson	VP & CFO

Turnover in upper management can change the direction of a carrier, and with change comes periods of change-over in operations to meet management's directives.

During the period under examination, the Company had a change-over in computer software which began during August 2004, and had not converted all of its membership as of June 30, 2006. The Company has encountered several difficulties during the change-over process, including problems which restricted its ability to process and settle claims in a timely manner.

The Company indicated it did not use Managing General Agents (MGAs) or Third Party Administrators (TPAs) during the period under examination. In addition, the Company indicated that it had not made a market withdrawal from any markets.

#### Adequacy of Records

The Company provided most of the files, records, and other data requested during the examination. The files and records were provided in an orderly manner, but not always in a timely manner.

However, during testing the Company indicated it failed to retain documents during a segment of the period under examination.

A Company response stated:

"Background:

On May 19, 2005 the server where the document images are stored suffered a 'hard crash' when a cooling fan malfunctioned. The drives were physically damaged by the crash. Though this created immediate access problems for users we were confident that all documents could be restored because the damaged server was backed up nightly on a server that was located in the Great Falls office. That restoration process was started and images were repopulated on a new server located in the Helena office. The process was extremely slow so IS (Information Systems) personnel went tot (sic) Great Falls and brought the backup server to Helena so that a direct connection could be made in order to expedite the restoration process. Even with the direct connection, the half terabyte of data took multiple days to copy back. Once that was completed it became apparent that we were still missing several months' worth of data. Upon further evaluation we discovered that the backup server in Great Falls had stopped receiving the nightly data in October of 2004. Therefore, none of the images between October and May 19th had been backed up. The backup process had been set up, as an automated function to occur nightly but there wasn't an automated monitoring method in place at the time. Monitoring successful transmission had been a manual effort. IS explained that an individual had been assigned that task when it was originally set up but due to management and position changes it was a task that became 'lost in the shuffle.'

Recovery Steps:

The Micro Imaging Team also made backups. These are performed periodically and files are copied to DVD. This is done for archival purposes and to free up space in the on line repository. Every electronic cabinet is copied to a DVD at the end of a calendar quarter. In addition, document types that generate large quantities of material are copied to disk as soon as there is enough volume to fill a disk so they occur more frequently - such as claims.

Therefore, we were able to restore images up through at least March 30th of 2005 from these backup disks.

This left us with a gap of documents that were scanned between April 1 through May 19th for some document types and for a shorter period for document types with large volumes of material.

Some of the documents were still available in their original paper form. The documents that were on hand were rescanned and made available in the Imaging system. Not all paper is kept and many document types from this period had already been destroyed.

The damaged server was sent to specialty service in an effort to recover the remaining data forensically. The company was able to pull many of the electronic images and present them to us on a hard drive. Unfortunately, the corresponding index files were not recoverable. The index file is what makes a particular image identifiable and locatable. Many documents are multi-paged tiffs and the way the technology organizes them on the server drive is a random pattern based on available space. This meant that a multi paged document would have its various pages scattered amongst many thousands. Most pages do not carry individually identifiable indicators that would allow them to be reconnected even when attempted by manually/visually seeking them out. Many hours were spent attempting to find even one document and its corresponding pages. We tried many different documents that we knew should have been on that drive and could not reconnect or even positively locate even one of them. Many of the image files were actually corrupted by the physical damage and could not be opened or viewed. Portions of the image were visible while other portions were wiped away.

A meeting was held with the leaders of Legal and Compliance Department. They were presented with the successes and the shortcomings in the recovery efforts. It was determined the images that were forensically recovered from the server could not be trusted and were considered officially lost.

In one additional attempt to recover more documents, the Micro Imaging Team did an inventory of documents that were known to have been in each department's electronic file cabinets and compared it to what had been restored to date. From this, a detailed and specific document, lists were created indicating what images were still missing. These lists were provided to each department and they were asked to search their paper files and return any documents from the lists that were on hand in their areas. Additional records were recovered in this manner but many could not be recovered because, in most cases, the documents are procedurally destroyed after imaging.

Procedures have been put in place to ensure this unfortunate series of events does not reoccur."

Therefore, the Company failed to maintain some records and data for examination purposes.

## **COMPLAINT HANDLING**

There were 765 SAO Complaint files during the period under examination. Due to the Complaint reasons, 125 of the files were excluded. Testing indicated there were 21 files concerning BCBS insurers of other states and 35 other files were for ASO plans. Therefore, those files were excluded from testing. In addition, the Company provided 18 of the 125 files originally excluded from testing. Therefore, the total number of files

tested was (765-125+18-21-35 = 602) 602. The table below indicates the results of testing for Complaint Standard numbers 1 and 3.

		Standard #1	Standard #3	
	# Complaints Tested	Failed Retain Files	Failed Underlying Issue	% Failed
SAO Complaints	602	5	31	6%

**Complaint Handling Standard #1:** *The Company has adequate complaint handling procedures in place and communicates such procedures to policyholders in compliance with §§ 33-18-1001 and 33-31-303, MCA.*

*Recording of complaints includes:*

- 1. number of complaints;*
- 2. classification by line of business;*
- 3. nature of the complaint;*
- 4. disposition of the complaint;*
- 5. time it took to process each complaint; and*
- 6. provides the telephone number and address for consumer inquiries.*

The Company is efficient at recording in its log the assigned SAO number. BCBSMT generally documents its responses, received dates, nature of the complaint, and the disposition of the complaint in compliance with §§ 33-18-1001, MCA, or 33-31-303, MCA.

The Company could not locate two files and it could not locate documents for three other files. Failure to maintain complaint records was a violation of §§ 33-18-1001, MCA, or 33-31-303, MCA.

**Complaint Handling Standard #2:** *The Company's responses to the State Auditor's Office address the issues raised in the complaints and are provided timely in compliance with Montana statutes and rules.*

The SAO requests an insurer respond within 10 days of receipt of a complaint and the Company attempted to meet this standard. However, this period is often extended because it is necessary for the Company to gather information from other offices or providers. The Company attempted to respond quickly once it had gathered all the data associated with formulating a response to the issue(s) in a consumer complaint.

**Complaint Handling Standard #3:** *Test the Company's SAO Complaint files to determine if the underlying issue of the complaints were settled in compliance with Montana statutes and rules, and the HIPAA.*

- For one SAO Complaint file, the BCBSMT employer group contract contained a confinement clause in violation of §§ 33-22-514, 33-22-526, MCA and the HIPAA.

- For two SAO Complaint files, the Company failed to issue coverage in compliance with its underwriting guidelines in violation of § 33-18-206, MCA.

- An applicant was a federally eligible individual and the Company failed to provide coverage in violation of § 33-22-1513(2)(b), MCA. In addition, after the Company reconsidered and provided coverage, it failed to allow an effective date of coverage in compliance with § 33-22-1513(2)(b), MCA. The Company's actions also created a greater than 63 days gap in coverage for the insured.

- For one SAO Complaint file, the Company failed to issue the certificate of creditable coverage (CCC) in compliance with § 33-22-142(a), MCA and Admin. Rule 6.6.5079G(1).

- Testing of 11 SAO Complaint files indicated BCBSMT failed to deny or pay 38 claims timely in violation of § 33-18-232, MCA. The Company indicated it should have paid interest for one of the claims, and provided support that it paid the interest.

- The Company collected premium for a newborn dependent in violation of §§ 33-22-301(4) or 33-22-504(6) MCA, depending on whether the coverage was individual or group coverage. As a result of this file, and pursuant to a request from the DOI in 2002, the Company made refunds to other similarly affected members and discontinued billing premiums for the first 31 days of life.

- The Company failed to terminate an employer's coverage in compliance with its contract, billing notices and guidelines. The Company also failed to issue a CCC in compliance with § 33-22-142, MCA, and Admin. Rule 6.6.5079G.

- The Company's CCCs did not provide the proper waiting period date for the dependents. Therefore, the CCCs were issued in violation of § 33-22-142, MCA and Admin. Rule 6.6.5079G. Testing of other files indicated the Company's practices and procedures failed to allow it to provide accurate waiting periods on CCCs. The Company agreed its CCCs did not always provide proper waiting periods.

- An SAO Complaint file was failed because BCBSMT had not retained all records associated with the file in violation of § 33-18-1001, MCA, and did not allow the applicant seamless coverage in violation of § 33-22-1513(2)(b), MCA.

- The Company failed to retain two complaint files in violation of § 33-18-1001, MCA.

- The Company failed to recognize the insured's creditable coverage as such, and the Company's definition of "creditable coverage" was not in compliance with § 33-22-140(4), MCA. Therefore, the original denial of the creditable coverage for reducing the insured's waiting period for preexisting conditions was a violation of § 33-22-141, MCA, Admin. Rule 6.6.5079F and the HIPAA. The Company made an extensive review of their records following this complaint and resolved the only other similarly affected individuals.

- The Company issued a letter to a COBRA covered certificate holder that restricted the availability of conversion coverage in violation of § 33-30-1007, MCA. In addition, the Company violated § 33-30-1007, MCA, for every insured that was conversion eligible and was offered conversion in the same manner. The Company indicated that its "shell letter" for conversion applicants has been corrected.

- The Company refused to refund the insured's premium in violation of § 33-18-212, MCA. On appeal, premiums were refunded.

- There was an out of country claim filed by the insured, and the Company failed to process and pay the claim in compliance with § 33-18-232, MCA. In addition, interest should have been paid for compliance with § 33-18-232, MCA. BCBSMT has paid the provider interest in the amount of \$756.21.

- The Company provided evidences of coverage to employees, even though its contracts indicated that no coverage was in force until the Company received the premium for the first month. The receipt of evidences of coverage by the employees caused them to believe they had all of the benefits of the evidence of coverage, even though coverage was not granted. The Company violated § 33-31-312(1)(b), MCA, when it created the impression of coverage where none existed. This violation will be remedied by the Company making the contract provision more conspicuous and prominent in its contracts. In addition, the Company failed to terminate coverage at the time its contracts indicated that coverage would be terminated. When the Company failed to cancel its employer groups timely, it was issuing CCCs in violation of § 33-22-142, MCA. For one file, the notice of cancellation was not timely, in violation of § 33-22-530, MCA.

- For two Complaint files, the Company failed to put the employee's name on a CCC in one file, and the effective date of coverage was not on the other. Therefore, both CCCs, violated § 33-22-142, MCA and Admin. Rule 6.6.5079G. In addition, for one of these Complaint files, the Company extended the waiting period for a period greater than 12 months for newly hired employees in violation of Admin. Rule 6.6.5079(1) and 6.6.5079J(1). The Company agreed its practices allowed waiting periods greater than allowed, and indicated it was developing a corrective action plan.

## APPEALS/GRIEVANCES PROCEDURES

The Company provided appeals from two software systems that were utilized during the period under examination. The Company supplied a listing of 3,721 appeals from one system. Appeals with certain subject matters were eliminated, leaving a population of 2,053 files. Twenty-five files were sampled from that system. The Company provided a listing of 22,718 appeals from the second system. Appeals with certain subject matters were eliminated, leaving a population of 18,077 files. Fifty files were sampled from this system. One file was failed for both Standards tested. A total of four files were failed. The results of testing the 75 files are provided in the table below.

		Standard #1	Standard #2	
	# Appeals tested	Failed Retain Files	Failed Decision	% Failed
SAO Complaints	75	3	2	5%

**Appeals/Grievances Procedures Standard #1:** *A health carrier shall maintain an appeal/grievance register consisting of written records to document all appeals received during a calendar year in compliance with §§ 33-18-1001 and 33-31-303, MCA. First level reviews of adverse utilization review determinations should not be considered an appeal for the purposes of maintaining an appeals register. For each appeal, the register shall contain, at a minimum, the following information:*

- (1) *a general description of the reason for the appeal;*
- (2) *the date the appeal was received;*
- (3) *the date of each review or hearing;*
- (4) *the resolution at each level of the appeal;*
- (5) *the date of resolution at each level; and*
- (6) *the name of the covered person for whom the appeal was filed.*

For three files, the Company failed to maintain the files in their entirety in violation of §§ 33-18-1001 or 33-31-303, MCA, depending if the plans were for managed care or indemnity plans.

**Appeals/Grievances Procedures Standard #2:** *Test a Sample of appeal/grievance files to determine if the Company decides its appeals in compliance with its contract language, utilization review, its established practices and procedures, and not in an unfairly discriminatory manner.*

- The Company failed to pay an insured's claim in compliance with § 33-18-201, MCA, and failed to approve payment of the claim during the appeals process. The Company indicated it should have allowed benefits for the services rendered. The Company reprocessed and paid the claim during the examination.

## MARKETING AND SALES

**Marketing and Sales Standard #1:** *Review advertising materials in conjunction with the appropriate policy form. Test all advertisements and sales materials to determine compliance with applicable Montana statutes and rules. Marketing and Producer materials should not conflict with Montana statutes and rules, and the HIPAA, and therefore should not:*

1. *Misrepresent policy benefits forms or conditions by failing to disclose limitations, exclusions or reductions or use terms or expressions which are misleading or ambiguous*
2. *Make unfair or incomplete comparisons with other policies*
3. *Make false, deceptive or misleading statements or representations with respect to any person, company, or organization in the conduct of insurance business*
4. *Offer unlawful rebates*

The Company provided 164 Marketing and Sales materials used during the period under examination, including consumer advertisements, outlines of coverage and producer materials. The Company's internet website was also tested. The table below provides the results of testing the Marketing and Sales Materials.

	# Materials Tested	Materials Failed	% Failed
Marketing & Sales Materials	164	114	69.5%

- A BCBSMT marketing material indicated that five of the Associations provided health insurance coverage required life insurance coverage for all groups, which violated § 33-22-1811, MCA, Admin. Rule 6.6.5078(5) and the HIPAA, for small groups. Therefore, the marketing material was in violation of §§ 33-18-202 and 33-30-305, MCA.

- The Blue Select Outline of Coverage (OOC) restricted OB/Gyn care to one visit annually in violation of § 33-22-1904(2), MCA. The Montana Health, Montana Care, and Blue Choice plans issued prior to June 2003 and the Blue Select plans issued prior to January 2204 do not state that the participating OB/Gyn may be selected as the person's primary care physician. The HMO Montana Large Group evidence of coverage states that the person must notify their PCP prior to self-referral for OB/Gyn services in violation of §§ 33-22-1904(1), and 33-31-111(6)(b), MCA.

- The brochure, *Lost Your Health Insurance?*, indicates the applicant will avoid waiting periods (pre-existing condition limitations) if the application for individual coverage is made within 63 days of termination of group coverage (only a 30-day gap is allowed) and omitted that 3 months of coverage for group health insurance is a

prerequisite to application for conversion coverage. The brochure provided incorrect information in violation of §§ 33-30-305(1)(a)(b), 33-30-1007(1) and/or 33-31-312, MCA.

- The Company's "Conversion Plans" brochure stated that to avoid a preexisting condition limitation under conversion coverage, the member had to have *continuous coverage under BCBSMT* coverage, in violation of § 33-22-140(4), MCA, and the HIPAA. In addition, the brochure stated there is a *36 month look-back period* for preexisting conditions, which was a violation of § 33-30-1008, MCA. Therefore, the language was misleading, in violation of §§ 33-18-202, 33-30-305 and/or 33-31-312, MCA. The Company agreed to work with the SAO to clarify the brochure.

- Ninety-nine of the Company's individual and group marketing materials indicated that "Well Child Care," was applicable to children 24 months of age or less in both managed care and indemnity plans. In addition, the BCBSMT website also listed plans providing "Well Child Care" benefits for children up to 24 months of age, which was in violation of §§ 33-30-1014 and 33-31-102(2)(h)(i) and (ii). Therefore, the marketing materials were misleading in violation of §§ 33-30-305 and/or 33-31-312, MCA.

**Marketing and Sales Standard #2:** *Determine if the Company disclosed to all small employer groups, as part of the Company's solicitation and sales materials, information in compliance with Admin Rule 6.6.5079E, and the HIPAA. Disclosure is to include the following provisions of coverage relating to:*

1. *The extent to which premium rates for an individual and dependents are established or adjusted based upon rating characteristics found at § 33-22-1809, MCA;*
2. *The description of benefits in summary form;*
3. *The rate or rating schedule that applies to the plan;*
4. *The provisions relating to renewability of policies and certificates;*
5. *Any provisions relating to preexisting condition(s);*
6. *The minimum employer contribution and group participation rules; and*
7. *In the case of a network plan, any affiliation periods and a map or listing of the counties served and a list of the providers in the network.*

The Company supplied the marketing material used for solicitation of small employer groups. No exceptions were noted.

## **NETWORK ADEQUACY**

**Network Adequacy Standard #1:** *The Company files its access plan with the Department of Health and Human Services for each managed care plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing managed care plan.*

1. *The carrier makes the access plans available on its business premises, to regulators, and interested parties absent proprietary information upon request.*
2. *BCBSMT provides coverage for emergency services twenty-four hours per day, seven days a week within its network, and provides coverage for emergency services outside its network in compliance with § 33-36-205, MCA.*
3. *The Company executes written agreements with each participating provider in compliance with §-33-36-202, MCA.*
4. *The Company provides Provider Directories for its participating providers at enrollment, and updates its directory on a timely and reasonable basis.*

There were no exceptions noted during the testing of Network Adequacy.

## **PRODUCER LICENSING**

**Producer Licensing Standard #1:** *Testing of producer licensing was completed to determine:*

1. *if the producers are licensed and appointed in compliance with § 33-17-201, MCA;*
2. *if appointment forms were properly completed and completed prior to the producer writing business on behalf of the company;*
3. *if producers are acting within the scope of that authority.*
4. *reconcile the Company's lists with corresponding SAO producer lists to determine if there are discrepancies (refer discrepancies to the SAO);*
5. *compliance with termination notification period and allowance for renewal commissions; and*
6. *if commissions are paid in compliance with the contracts.*

Producers and producer contracts were sampled and none of those files were failed. However, the Company's agencies were also tested by reconciling the SAO's listing with the Company's listing. Testing indicated violations as noted below.

- The Company failed to appoint five (5) agencies that were acting on its behalf in violation of §§ 33-17-231 and 33-17-236, MCA. The Company also failed to terminate five (5) agencies in violation of § 33-17-231, MCA. During the examination, the Company provided the SAO with filings for new producers and agencies, and also updated its producers and agencies that were terminated.

## **PROVIDER CREDENTIALING**

**Provider Credentialing Standard #1:** *Testing was completed to determine if the Company:*

1. *establishes and maintains a program for credentialing and re-credentialing in compliance with Montana statutes and rules;*
2. *verifies the credentials of a health care professional before entering into a contract with that health care professional;*
3. *obtains primary verification of the information from the State of Montana for verification of the credentialing;*
4. *every three years obtains verification of the credentialing information;*
5. *requires its providers to notify a designated individual of changes in status of any required information;*
6. *monitors the activities of the entity with which it contracts to perform credentialing functions (if applicable).*

There were no violations noted during the testing of Provider Credentialing.

## **POLICYHOLDER SERVICE**

**Policyholder Service Standard #1:** *Testing was completed to determine if the Company:*

1. *issues policies and endorsements, and applicant's questions in a timely manner;*
2. *allowed for insured requested terminations to be handled in a timely manner without excessive paperwork requirements for the insured;*
3. *issues billing statements to ensure timeliness for the insured to make payments;*
4. *policy lapse and reinstatement provisions were applied consistently, in a nondiscriminatory manner, and reinstatements are applied per policy provisions;*
5. *quote procedures for handling renewal business is in compliance with Montana guidelines;*
6. *complies with the provisions of COBRA and the HIPAA with respect to continuation of coverage, including required notice periods for withdrawing products from the market.*

There were no exceptions noted during testing of Policyholder Service for Standard #1.

**Policyholder Service Standard #2:** *During the testing of all files, review contract language that supports the Company's decisions, procedures and practices to determine if the contracts/certificates contain language that is in compliance with Montana statutes and rules, and in compliance with the HIPAA.*

Policy, contract and certificate language was only tested if materials, data, or files from other testing indicated the Company's language should be tested to determine if it complied with Montana and federal law.

- The Company's large and small group certificates and contracts for indemnity and managed care plans had two exclusions concerning conversion coverage that were not in compliance with § 33-30-1007(1), MCA.

- The BCBSMT Montana YouthCare policies allowed for termination when a dependent attained the age of 31 days in violation of § 33-22-301(2), MCA.

- The Company's contracts stated that well child care coverage was applicable to children up to 24 months of age and the contracts failed to outline all of the covered person's options regarding OB/Gyn referrals and care.

**Policyholder Service Standard #3:** *Test the WHCRA Enrollment and Annual Notices provided during the period under examination to determine if the notices contain language as required by the WHCRA (Center for Medicare and Medicaid Services, "CMS.")*

The Company provided its WHCRA notice documents.

## QUALITY ASSESSMENT AND IMPROVEMENT

**Quality Assessment and Improvement Standard #1:** *Testing was completed to determine if the Company:*

1. *developed and maintains a quality assessment program in compliance with § 37-108-506(3), ARM and 33-36-302, MCA;*
2. *filed a written description of the quality assessment program with the Department of Health and Human Services, and annually certifies its quality assessment and quality improvement program;*
3. *developed and maintains a quality improvement program in compliance with Montana statutes and rules;*
4. *reports to the appropriate licensing authority any persistent pattern of problematic behavior by a provider that is sufficient to cause the Company to terminate or suspend contractual arrangements with the provider;*
5. *documents and communicates information about its quality assessment program and its quality improvement program to covered person and providers.*

There were no violations noted during the testing of Quality Assessment and Improvement.

## UNDERWRITING

### SMALL GROUPS

**Small Group Underwriting Standard #1:** *Determine if small employer groups were issued in compliance with Montana statutes and rules, and the HIPAA.*

From a population of 1,731 Small Employer Groups Issued, 70 files were sampled. Ten of the sampled files were not applicable and were excluded. Therefore, 60 files were tested and 12 files failed. The Company did not retain all documents for one file. The results of testing are indicated in the table below.

Files Tested	Failed How Issued	% Failed
60	12	20%

- For two files, the Company provided the small employer with an incorrect SIC (industry) code in violation of § 33-22-1809(1)(f), MCA.

- As noted in Complaint Handling Standard #3, the Company issued evidences of coverage to employees prior to payment of the premiums by the employer.

- The Company allowed one small group employer and one Merit small group employer to waive the waiting period for one employee respectively and enforced the waiting period upon other employees in violation of § 33-22-1811(3). For two Small Group Issued files, the employers elected a waiting period of 365 days. For employees hired after the group's initial effective date of coverage, the waiting period was extended past the allowable twelve-month period in violation of ARM 6.6.5079. The Company agreed it was allowing waiting periods greater than allowed. The applications used for both small and large groups allowed the employer to waive the waiting period for some employees while imposing it upon other individuals in violation of § 33-22-1811, MCA.

- BCBSMT small group applications eliminated the necessity for a notice of an adverse underwriting decision, which is required under § 33-19-303, MCA. The company agreed and indicated it was in the process of changing its applications.

**Small Group Underwriting Standard #2:** *Determine if small employer groups that had coverage discontinued, were terminated in compliance with § 33-22-524, MCA, Admin. Rules 6.6.5079D, other Montana statutes and rules, and the HIPAA. In addition, determine if certificates of creditable coverage were issued in compliance with § 33-22-142(1), MCA, Admin. Rules 6.6.5079G and the HIPAA.*

From the population of 2,343 Small Groups terminated, 100 files were sampled. Eight of the files were duplicates and three of the small groups were never canceled. Therefore, a total of 89 files were tested. The sample of 89 files was divided into segments A and B. Segment A is for terminations on and after the effective date of § 33-22-530, MCA, and Segment B is for those files terminated before the statutory change, on January 1, 2004.

In Segment A there were 66 files. The Company failed to retain 9 of the files and a total of 25 CCCs were issued late. In Segment B there were 23 files, 3 CCCs were issued late and the Company failed to retain 3 files. The combined results for Segments A and B are listed in the table below.

# Files	CCC Late	% Failed
89	28	31%

All of the CCCs that were issued timely and those that were issued late had either an incorrect effective date of coverage or were issued with an incorrect waiting period. Therefore, all files failed this test in violation of § 33-22-142, MCA, and some files failed for multiple violations of § 33-22-142, MCA. The Company agreed and stated that steps have been taken to correct this situation.

**Small Group Underwriting Standard #3:** *Determine if any small employer groups were declined coverage in violation of § 33-22-1811, MCA, Admin. Rules 6.6.5079A, other Montana statutes and rules, and the HIPAA.*

The Company indicated it had not declined coverage for any small employers.

**Small Group Underwriting Standard #4:** *Determine if any small employer groups had coverage rescinded in violation of Montana statutes and rules, and the HIPAA.*

The Company indicated it had not rescinded coverage for any of its small groups.

**Small Group Underwriting Standard #5:** *Determine if small employer groups were rated in violation of §§ 33-22-1809 and 33-22-526, MCA, Admin. Rules 6.6.5079D, or other Montana statutes and rules, and the HIPAA.*

- The Company rated Community plans outside the 15% renewal rating provisions allowed by § 33-22-1809, MCA. The only data available for the period under examination was for years 2003, 2004, 2005, and 2006. The Company initially indicated that it had allowed 214 small employer groups to be rated for renewal at amounts greater than allowed under § 33-22-1809, MCA. The Company later stated that 82 groups had been rated incorrectly. The matter will be further reviewed by the State Auditor's Office.

## **LARGE GROUPS**

**Large Group Underwriting Standard #1:** *Determine if large employer groups were issued in compliance with Montana statutes and rules, and the HIPAA.*

The Company supplied its Merit Groups (the Company's term for large group business) Issued for its population of Large Groups Issued. There was a population of 4,005 Merit Groups issued. However, not all Merit Groups are large employers; some employers contained within association groups are small employers. Therefore, the 50 files sampled included small employers. Five of the files were not applicable as newly issued files. Therefore, those files were eliminated, leaving a total of 45 files tested.

The Company failed to retain 6 files. A total of 5 files were failed, and the results of the testing are indicated in the table below.

Files Tested	Failed How Issued	% age Failed
45	5	11%

- The Company failed to retain documents for four Merit Groups and could not locate the rating information for two other files. The Company agreed it could not locate the underwriting files and the rating information.

**Large Group Underwriting Standard #2:** *Determine if large employer groups that had coverage discontinued, were terminated in compliance with § 33-22-524, MCA, and/or other Montana statutes and rules, and the HIPAA. In addition, determine if certificates of creditable coverage were issued in compliance with § 33-22-142(1), MCA, and the HIPAA.*

Twenty files were sampled from a population of 614 Merit Groups Terminated. However, 9 of the files were simply moved to other subgroups or given a new number and coverage was not terminated.

- For Merit Groups Terminated, six of the employer groups did not have CCCs issued timely, none of the waiting periods on the CCCs were correct, and the Company did not retain the records of the cancellation notices or of the reason three groups were terminated. Therefore, some of the files were failed for violations of § 33-22-142(1), MCA.

**Large Group Underwriting Standard #3:** *Determine if any large employer groups were declined coverage in violation of Montana statutes and rules, and the HIPAA.*

- There were 14 Large Groups declined during the period under examination. All of the files were tested. One file could not be located and the Company agreed it could not locate the underwriting file. There were no other exceptions noted.

**Large Group Underwriting Standard #4:** *Determine if any large employer groups had coverage rescinded in violation of Montana statutes and rules, and the HIPAA.*

The Company indicated it did not rescind coverage for any of its Merit groups.

## **INDIVIDUAL POLICIES**

**Individual Policies Underwriting Standard #1:** *Determine if individual policies were issued in compliance with Montana statutes and rules, and the HIPAA.*

- From a population of 35,501 Individual Issued plans, 100 files were sampled. Five of the files weren't applicable for testing. Therefore, a total of 95 files were tested.
- For three Individual Issued files, the Company failed to retain all the records associated with the files. The Company agreed that it could not locate the documents.

- For one Individual Issued file, the Company provided an incorrect medical condition exclusionary rider in violation of § 33-22-109, MCA. The Company agreed it assigned an inappropriate rider.

**Individual Policies Underwriting Standard #2:** Determine if individual policies that had coverage discontinued, were terminated in compliance with § 33-22-247, MCA, and/or other Montana statutes and rules, and the HIPAA. In addition, determine if certificates of creditable coverage were issued in compliance with § 33-22-142(1), MCA, and the HIPAA.

The Company provided a population of 26,457 Individual Terminated policies. A sample of 125 files was extracted and three policies were excluded. The files were excluded because one policyholder was transferred to a new plan and two were not canceled. No files were failed for record retention. A total of 122 files were tested and the results of testing are indicated in the table below.

Files Tested	Late CCC	No CCC Issued	CCC% Failed	Failed Term Reason
122	13	1	11%	11 files – 9%

For the Individual Terminated files, the Company never issued one CCC, and issued 13 CCCs late in violation of § 33-22-142(1), MCA and the HIPAA.

**Individual Policies Underwriting Standard #3:** Determine if individual policies were declined coverage in violation of Montana statutes and rules, and the HIPAA.

From a population of 7,725 Individual Applicants Declined, 100 files were sampled. Two files were failed because the Company could not produce the files. In addition, there were seven files failed because the Company failed to decline the applicants in compliance with Montana statutes and/or rules. Therefore, a total of 7 files were failed as indicated in the table below.

Files Tested	Failed How Declined	% Failed
100	7	7%

- For two Individual Declined files, the Company could not locate the underwriting files. The Company agreed that it could not provide the files.

- The Company failed to provide the “specific reasons” in two Adverse Underwriting Notice letters in violation of § 33-19-303, MCA.

- The Company declined four Medicare supplement plan applications in violation of Admin. Rule 6.6.507C and the federal Medicare Program Memorandum for Insurance Commissioners and Insurance Issuers, Transmittal No. 01-01, June 2001. The Company agreed that one of the four declined files should have been approved.

- The Company was requested to provide all of the declined Medicare supplement applications. The population of 377 Medicare supplement declinations provided includes the four files previously mentioned. Testing of the files indicated that 131 of the 377 files were failed.

Files Tested	Files Failed	% Failed
377	131	35%

- For ninety files, the applicants had prior group coverage and had not used their open enrollment option or should have been guaranteed issue.

- For one file, the applicant applied for open enrollment twice during the initial 6 month period and the Company allowed the first open enrollment and disallowed the second open enrollment. CMS Transmittal No. 02-21 clarified that Medicare beneficiaries may apply for more than one Medicare supplement policy during their open enrollment period.

- For seventeen files, the applicants were in a special enrollment period. Failure to allow eligible individuals special enrollment is a violation of Admin. Rule 6.6.507C.

- For nineteen files, the Company failed to maintain the full records associated with the underwriting files (17 of the files did not have an application retained by the Company).

Four applicants were transferring to another Medicare supplement plan to comply with the new Part D coverage of Medicare. Failure to allow Plan J participants to enroll in another Medicare supplement during the initial enrollment for Medicare Part D is a violation of Admin. Rule 6.6.507C.

**Individual Policies Underwriting Standard #4:** Determine if individual policies were rated in violation of Montana statutes and rules.

There were no violations noted during testing of rating the individual market plans.

## CONVERSION POLICIES

**Conversion Policies Underwriting Standard #1:** *Determine if conversion policies were issued in compliance with Montana statutes and rules, and the HIPAA.*

The Company supplied a population of 466 Conversion policies issued. Fifty files were sampled for testing. Twenty-five files were eliminated from testing for various reasons, including: the policies were never issued, newborns were being added to the coverage of a parent, duplicates, or other reasons. Therefore, a total of 25 files were tested. The Company did not retain 4 of the files.

- The Company failed to provide a Basic Conversion plan required by § 33-30-1007, MCA, with benefits mandated at § 33-30-1007(4), MCA. The Company agreed that it did not file a Basic Conversion plan in compliance with § 33-30-1007(2) and (4), MCA.

**Conversion Policies Underwriting Standard #2:** *Determine if conversion policies that had coverage discontinued, were terminated in compliance with § 33-22-247, MCA, or other Montana statutes and rules, and the HIPAA. In addition, determine if certificates of creditable coverage were issued in compliance with § 33-22-142(1), MCA, and the HIPAA.*

From a population of 299 Conversion Terminated files, 25 files were sampled. Nine files were eliminated from testing for various reasons. Of the remaining 16 files, 6 CCCs were not issued when required and 2 were not issued timely in violation of § 33-22-142(1), MCA, and the HIPAA.

**Conversion Policies Underwriting Standard #3:** *Determine if conversion policy applicants were declined coverage in violation of Montana statutes and rules, and the HIPAA.*

The Company stated that it does not track Conversion Declinations. Therefore, testing could not be performed to determine if the Company issued "adverse underwriting decisions" in compliance with § 33-19-303, MCA.

The Company's group contracts and certificates limited access for conversion eligible individuals in violation of § 33-30-1007, MCA, as noted during testing of "Policyholder Services," in "Contract Language." Because the Company did not track Conversion Declinations, testing could not be completed to determine if the Company declined Conversion eligible individuals in violation of § 33-30-1007, MCA.

**Conversion Policies Underwriting Standard #4:** *Determine if conversion policy applicants/insureds had coverage rescinded in violation of Montana statutes and rules.*

There were no Conversion plans rescinded.

## UTILIZATION REVIEW ACTIVITIES

**Utilization Review Activities Standard #1:** *Testing was completed to determine if the Company:*

1. *has established and maintains a utilization review program in compliance with Montana statutes and rules;*
2. *conducts provider related utilization review activities in a timely manner in accordance with Montana statutes and rules;*
3. *conducts utilization review activities and provides for emergency services in compliance with Montana statutes and rules;*
4. *has filed and maintained its utilization review plan with the commissioner in compliance with § 33-22-103, MCA.*

There were no violations noted during the testing of Utilization Review. However, during testing of a Pre-Authorization file, one medical guideline allowed for pre-existing conditions exclusions when not allowed. The guideline was changed by the Company.

## CLAIMS AND PRE-AUTHORIZATION OF SERVICES

### CLAIMS PAID AND DENIED

**Claims Standard #1:** *Determine if paid claims sampled were processed and paid in compliance with Montana statutes and rules.*

From a population of 10,412,947 Paid Claims from 1/1/03 through 6/30/06, 100 files were sampled for the period 1/1/03 through 6/30/06, and 100 files were sampled for the period 7/1/05 through 12/31/05. Of the 100 files tested, for the period 1/1/03 through 6/30/06, no exceptions were noted. Of the 100 files tested, for the period 7/1/05 through 12/31/05, one file was failed for not paying the claim timely. The results of testing are indicated in the table below.

# Paid Claim Files Tested	Failed Claims Handling	Failed Retain Files	% age Failed
200	1	0	.5%

- The Company failed to pay one claim within 30 days in compliance with § 33-18-232, MCA.

- The Company initially processed and paid a portion of a claim timely. The Company reprocessed and paid the correct amount on the claim 176 days later.

**Claims Standard #2:** *Determine if denied claims sampled were processed and denied in compliance with Montana statutes and rules.*

From a population of 2,351,336 Claims Denied from 1/1/03 through 6/30/06, 100 files were sampled for the period 1/1/03 through 6/30/06 and 100 files were sampled for the period 7/1/05 through 12/31/05. Of the 100 files tested, for the period 1/1/03 through 6/30/06, three claims were not denied timely and interest was initially not paid on two claims. Of the 100 files tested, for the period 7/1/05 through 12/31/05, no exceptions were noted.

# Paid Claim Files Tested	Failed Claims Handling	Failed Retain Files	% age Failed
200	5	0	2.5%

- BCBMST failed to timely deny three claims.
- BCBSMT failed to pay interest when due for two claims in violation of § 33-18-232, MCA. The Company later initiated the process to pay the interest.

**Claims Standard #3** – *Determine if Montana mandated benefit claims sampled were processed and denied or paid in compliance with Montana statutes and rules.*

Of the population of 741,766 Montana Mandated Claims, 107 were sampled for the period 1/1/03 through 6/30/06. The Company failed to timely deny two Mandated Benefit Claims and failed to timely pay five Mandated Benefit Claims. A total of 7 files failed.

# Paid Claim Files Tested	Failed Claims Handling	Failed Retain Files	% age Failed
107	7	0	6.5%

- BCBSMT failed to timely deny two Mandated Claims in violation of § 33-18-232, MCA. The Company agreed that one file was not denied timely.
- BCBSMT failed to timely pay five Mandated Claims with liability in violation of § 33-18-232, MCA.

**Claims Standard #4** – *Determine if litigated claims sampled were processed and denied or paid in compliance with Montana statutes and rules. Determine if litigated files indicate problematic claim handling practices.*

No exceptions were noted.

### PRE-AUTHORIZATION OF SERVICES

The Company provided a population of 75 Denied Pre-Authorization for benefits files associated with a procedure for a transplant, breast reconstruction, gynecomastia and maternity benefits. Four of the files were not applicable. Therefore, a total of 71 files were tested. The Company failed to maintain records for two of the files and could not locate all of the documents for a third file and for Standard #2, one file failed for the reason it was denied.

**Pre-Authorization of Services Standard #1:** *A health carrier shall maintain its records for examination purposes in compliance with §§ 33-30-105 and 33-1-408, MCA.*

The Company could not provide three of the Pre-Authorization files in their entirety. The Company agreed it could not locate the records.

**Pre-Authorization of Services Standard #2:** *Select a sample of pre-authorization denial files to determine if the Company is denying medical services in compliance with its contractual benefits, utilization review, Montana statutes and rules, the HIPAA, the WHCRA, the NMHPA and its established procedures.*

- The Company failed to maintain two of the files and could not locate all of the documents for a third file.
- For one Pre-authorization file, the Company denied pre-authorization for breast reconstruction in violation of § 33-22-135, MCA and the WHCRA. The Company reversed their decision on appeal and authorized the surgery.

## ACKNOWLEDGEMENT

In addition to the undersigned, Yvonne Sainsbury, AIE, AIRC participated in this examination.

Respectfully submitted,

A handwritten signature in cursive script, reading "Thomas D. McIntyre".

Thomas D. McIntyre, CIE, MCM, CPCU, FLMI, AIRC, APA, ARA, ACS  
Examiner-In-Charge  
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